TDH Prevention Case Management Standards and Guidance

Overview

These HIV Prevention Case Management (PCM) Standards are designed to augment the Centers for Disease Control and Prevention's (CDC) September 1997 *Guidance for HIV Prevention Case Management* (http://www.cdc.gov/hiv/pubs/pcmg/hivpcmg.pdf) and the Texas Department of Health's (TDH) Program Operating Guidelines and Procedures (http://www.tdh.state.tx.us/hivstd/guidelines/default.htm). This document will not duplicate the information in other sources unless considered necessary. Organizations should view these standards as minimum requirements for program excellence, and must develop local protocols to expand upon the guidance offered in all these documents.

HIV Prevention Case Management is an individual level, client centered intervention that targets people at high risk for HIV infection. Its goal is to promote the adoption and maintenance of HIV risk reduction behaviors for those clients with multiple, complex problems and risk-reduction needs. PCM is intended for clients who have difficulty initiating or sustaining practices that reduce or prevent HIV/STD ***acquisition, transmission or re-infection***. PCM integrates risk reduction counseling, support, and targeted referrals for medical, psychological and social services. Sessions may address the relationship between HIV/STD risk and substance use/abuse, STD infection and treatment, mental health or social and cultural factors influencing client risk. PCM is not intended to provide psychotherapy, even when the providers have the appropriate credentials and training to do so. Programs should remember that participating in PCM is always voluntary, and the intervention should be reserved for those clients with a willingness to discuss their personal risks for HIV/STD and to participate in risk reduction counseling on a regular basis.

In 2003, the CDC introduced an initiative to reduce the number of new HIV infections in the US. A centerpiece of this initiative is renewed emphasis on HIV prevention services for HIV+ individuals, and the CDC has specifically identified PCM as a preferred intervention for this population. However, programs should not consider PCM a placeholder for psychosocial case management, and should not consider HIV status a sole criterion for participation in their PCM program; PCM conducted with HIV+ persons must still focus on reduction of behavioral risk.

Programs employing this intervention should assure that PCM contains several ***core elements:***

- Client recruitment and engagement
- Screening, comprehensive risk assessment, and medical, psychological, and social service needs assessment

- Development of a client centered risk reduction plan
- Multi-session risk reduction counseling
- Active coordination and follow-up of services
- Monitoring and re-assessment of client needs, risk and progress toward goals
- Discharge planning upon attainment and maintenance of PCM risk-reduction goals
- Other program elements
    - Staff qualifications and training
    - Quality assurance and program evaluation

This document is aligned for discussion of each of these core elements.

Core Elements

Client Recruitment and Engagement

STANDARDS:

- ***A program must establish eligibility standards.***
- ***Recruitment methods, such as coordination of services and target population criteria, must be clearly defined.***

Before beginning client recruitment and engagement, PCM programs will need to establish eligibility standards. Standards will allow a program to maximize resources, reach targeted high-risk populations and ensure that appropriate caseloads are maintained. A recommended manageable range of active client caseload is 20-25 clients. Recruitment should also be in coordination with other agencies. TDH funded Prevention Counseling Partner Elicitation (PCPE)/PCM agencies should target priority populations with an emphasis on those who are HIV-positive. Programs should also recruit high risk, HIV-negative populations.

Programs should remember PCM is a voluntary service and should be reserved for individuals with a willingness to discuss their personal risk for HIV and to participate in HIV risk-reduction counseling on a regular basis. Agencies may wish to create recruitment criteria for individuals who are HIV-negative or of unknown status and for those that are HIV-positive. The recruitment criteria should be shared with community partners.

Highest priority should be given to HIV infected persons in the following categories:

- HIV+ persons engaging in unprotected vaginal and/or anal sex or sharing needles/works with partners of unknown or negative status
- HIV + persons with recently diagnosed STD
- HIV + persons with mental health or substance use issues that intensify risky behaviors
- HIV + persons who engage in sex trade, sex in high risk venues or who engage in anonymous sex

- HIV + persons with psychosocial and environmental issues that impact risk (e.g., homelessness, recent incarceration, violence)

In addition, HIV negative persons with the following risks are also priorities for PCM:

- Partners of HIV infected persons
- Persons who during the past three months have had risks in the following categories:
  - Multiple unprotected anal or vaginal sex events, especially with multiple partners
  - Recent or repeated diagnoses with a STD
  - Sharing needles/works
  - Substance use associated with sex
  - Mental health issues that exacerbate risk
  - Engaging in sex trade, sex in high risk venues or anonymous sex
  - Psychosocial and environmental issues that impact risk (e.g., homelessness, recent incarceration, violence)

Organizations must have written engagement protocols and plans

STANDARD:

- ***Agencies that utilize tangible reinforcements must be in agreement with TDH policy, have specific policies in place and use a tracking mechanism for those reinforcements.***

Agencies are encouraged to use both active and passive recruitment methods. Active methods include direct referral from PCPE as well as ***targeted*** outreach programs. Passive methods include referrals resulting from other prevention interventions, partners, Ryan White case managers, drug treatment clinics, and STD clinics and programs that have disease intervention specialists and surveillance. Agencies are encouraged to include these passive recruitment techniques in memorandums of agreement/understanding (MOA) that they develop with partner agencies. These agreements will enhance the referrals received and will result in a more comprehensive client management system. To increase participation, funded agencies may use non-monetary tangible reinforcements/incentives for client recruitment. If using passive recruitment, the PCM program will need to directly engage the client prior to the initial screening and assessment meeting.

STANDARD:

- ***Agencies must have protocols for client engagement and follow-up.***
  - ***A client must complete three (3) sessions with a prevention case manager to be considered as having completed the engagement phase.***
  - ***All three engagement sessions must be conducted in person.***

- ***If a client has not completed three (3) sessions, a minimum of two follow-up contacts within a two-week period must be made before the client file is closed.***
- ***Follow-up attempts must be documented.***

The engagement phase may include the screening and comprehensive risk assessment, as well as the beginning of the risk reduction plan. Prevention case management is designed to continue beyond the engagement period and continue until client centered goals are achieved or the client withdraws from service.

Screening and Comprehensive Risk Assessment

STANDARD:

- ***Agencies must develop screening procedures to prioritize persons at highest risk for acquiring or transmitting HIV and who are appropriate for PCM.***

The goal of screening and assessment is to assure the client is aware of the scope of PCM, meets eligibility standards, and is ready to engage in the process. Screening should include both eligibility standards, as well as prioritizing those clients eligible for enrollment or, if necessary, a waiting list for enrollment.

Agencies should have clearly defined risk categories of behavior or circumstances for prioritizing clients. In addition to risk, HIV+ clients should receive priority in PCM enrollment (i.e. if two clients have the same risk factors but one is HIV+ and the other is HIV-, the HIV+ client would receive priority for enrollment.) Sero-status alone would not be reason for enrollment into PCM. Prioritization should be based on risk and behavior in the past 3 months. Priority categories could include (in descending order):

Category 1 risk factors:

1. Multiple unprotected exposures with multiple partners (anal/vaginal/oral).
2. Multiple substance use issues associated with risk.
3. Mental health issues associated with risk (mental illness, depression, anxiety, shame, guilt, abuse).
4. Unprotected sex in high-risk venues (commercial sex work, public sex environments, bath houses, truck rest stops).

Category 2 risk factors:

1. Shared needles/works.
2. Has been diagnosed with a bacterial STD or newly diagnosed viral STD
3. Multiple episodes of unprotected anal, vaginal or oral sex.

Clients with psychosocial issues that impact risk (violence, homelessness, coercion) in tandem with other risk factors would receive top priority.

Using this methodology, a sample priority list of 4 clients might look like this:

An HIV+ client with psychosocial issues that impact risk (violence, homelessness, coercion) in tandem with at least 1 risk factor from category 1 or category 2.

An HIV+ client with more than 1 risk factor from category 1.

An HIV- client with more than 1 risk factor from category 2.

An HIV+ client with more than 1 risk factor from category 2.

STANDARD:

- ***All clients screened for PCM must be offered prevention counseling and at least one referral appropriate to their needs, even if PCM is not indicated.***
- ***All referrals require follow-up whether or not that client is enrolled into PCM.***
- ***All referrals and follow up activities must be documented.***

For referrals follow the guidelines and procedures found in chapter 12, Minimum Standards for Client Referrals of the TDH Program Operating Procedures and Standards manual.
http://www.tdh.state.tx.us/hivstd/guidelines/pdf/ClientReferralStandards.pdf

STANDARD:

- ***A comprehensive assessment of HIV, STD and substance abuse risk, as well as medical and psychosocial needs must be performed for each PCM client with client participation.***
- ***The comprehensive assessment must be documented for each PCM client.***
- ***The client must sign an informed consent that ensures confidentiality at the time of the assessment.***
- ***The client must sign a release of information for referral follow-up.***

Potential areas for assessment include: health status and history, access to care, adherence to HIV-related treatment, STD history, substance and alcohol use/abuse, mental health, sexual history, social and environmental support, skills to reduce HIV risk, barriers to safer behavior, protective factors, strengths, and competencies, and demographic information.

Development of a Risk Reduction Plan

STANDARDS:

- ***A written risk-reduction plan must be developed for each enrolled PCM client with his or her participation.***
- ***The risk-reduction plan must specifically define HIV risk-reduction behavioral objectives and strategies.***
- ***The risk-reduction plan must include SMART steps (specific, measurable, achievable, realistic, and time relevant).***
- ***Clients must sign off on risk reduction plans to indicate participation and commitment to the plan.***
- ***Plans for HIV+ clients must include goals for reducing unprotected vaginal/anal sex events with partners of unknown or negative status or maintaining 100% condom use during vaginal/anal sex with partners of unknown or negative status.***
- ***All agencies must make sure that the confidentiality of risk reduction plans are maintained and that all plans are kept locked up when not in use.***

There are multiple models that may be used in the development of the risk-reduction plan (stage based steps, harm reduction steps based on client's risk, logic models, etc).

In addition all plans should have the following characteristics:

- Well-defined milestone and specific steps to reach milestone.
- Plans for who is responsible for what and when.
- Plans for a 6-month assessment of risks and HIV/STD status.
- For those with sexual risk behaviors, plans for regular medical evaluation for STDs, even if symptoms are not present.
- Address issues of adherence to medication for clients who are on drug therapy for HIV and/or other STDs.
- Documented referrals for alcohol and drug treatment if the client identifies a substance use problem.
- If the client is involved in RWCM or related programs the prevention plan must detail this involvement to ensure coordination and/or integration of PCM and RWCM.
- Plans for HIV positive individuals to address disclosure to partners.
- A policy to offer a copy of the risk reduction plan to the client and allows client to accept or decline the copy.

Risk Reduction Counseling

STANDARDS:

- ***Multiple session risk-reduction counseling aimed at meeting the behavioral objective must be provided to all enrolled PCM clients.***
- ***Counseling sessions must be client-centered and address individual client needs.***
- ***Clients who are unaware of their serostatus must receive information regarding the benefits of knowing their status.***
- ***Clients must be educated regarding the increased risk of HIV transmission associated with other STDs and the prevention of these STDs.***
- ***Clients must be educated regarding the benefits of knowing their STD status.***
- ***Clients who are HIV + must receive secondary prevention counseling, (i.e. clients who receive treatment for opportunistic infections and/or antiretroviral therapies must be provided counseling to support adherence to treatment therapies).***

If applicable, counseling should explore client barriers to testing and seek to identify strategies to overcome these barriers.

STANDARD:

- ***Prevention case managers are expected to maintain adherence to TDH Partner Elicitation and Notification Standards.***

Refer to chapter 3, HIV Partner Services and Seropositive Notification of the TDH Program Operating Procedures and Standards manual.
http://www.tdh.state.tx.us/hivstd/guidelines/pdf/HIVPartnerServicesandSeroNotificationStandards.pdf

Active Coordination and Follow-up of Services

STANDARDS:

- ***All PCM programs need to establish formal, written agreements/MOUs with relevant service providers to ensure availability and access to key services.***
- ***A written referral mechanism must be established.***
- ***Agencies must follow guidelines and procedures regarding minimal standards for client referrals of the TDH Program Operating Procedures and Standards manual.***
- ***Agencies must maintain a tracking system for referrals made and completed.***
- ***Written protocols for communication and coordination between case managers and/or counselors in different organizations are required to avoid duplication of services.***

- ***Written client release of information must be obtained prior to the sharing of any information with other providers. Documentation of this release must remain with client chart.***
- ***Agencies must perform an annual review and assessment of relevant community providers to maintain current referral and access information.***
- ***PCM programs must also establish an emergency protocol for providing* or *referring to emergency psychological and/or medical services.***

The written referral mechanism should outline a process for semi-annual follow-up with providers on the appropriateness of referrals. A written process for client feedback on referrals should also be established.

Refer to chapter 12, Minimum Standards for Client Referrals of the TDH Program Operating Procedures and Standards manual.
http://www.tdh.state.tx.us/hivstd/guidelines/pdf/ClientReferralStandards.pdf

PCM is not designed to replace other case management services unless staff is qualified to perform those services and they are within the scope of the program (e.g. Medicaid case management for pregnant women and infants, MHMR case management, etc). Coordination requires written client informed consent prior to sharing any information with other providers. Obtaining this consent may be included as part of the initial screening and assessment.

MOAs should be reviewed annually to assure access to care and services.

Clients should be informed about how emergency referrals to psychological and/or medical services are handled as part of the risk reduction planning.

STANDARD:

- ***PCM may be integrated with RWCM but must not duplicate services.***
- ***Coordination of PCM with Ryan White Care Act Case Management (RWCM) must be a key element of an agency's PCM protocol.***
    - ***The protocol must explicitly define the relationship between RWCM and PCM and detail how duplication of services will be avoided.***

To avoid duplication of services for a client receiving RWCM, initial contact/communication with the Ryan White case manager should occur during the initial engagement sessions or as soon as it is learned that the client has begun receiving those services. Active and open dialogue regarding client services should occur in order to integrate PCM with RWCM without duplicating services.

Monitoring and Re-assessment of Client Needs, Risk and Progress Toward Goals

STANDARDS:

- ***Prevention case managers must meet on a regular basis with clients to monitor their changing needs and progress toward meeting HIV behavioral risk-reduction goals.***
  - ***The frequency of individual meeting should be determined based on client needs but must meet one of these scenarios:***
    - ***The initial three (3) engagement sessions must occur within the first month.***
    - ***For clients with less than six (6) months of enrollment, a minimum of one (1) scheduled meeting per month is required.***
    - ***For clients with greater than six (6) months of enrollment, a minimum of one (1) scheduled meeting per quarter is required, with assessment of frequency determined and documented at those meetings.***
- ***All individual meetings and results must be documented in the client's confidential record.***
- ***A written protocol must be developed for actively retaining clients in case management. The protocol must describe:***
  - ***Steps to be taken for client follow-up,***
  - ***Criteria for making clients inactive,***
  - ***The outline for use of tangible reinforcements for client retention.***

After completing the three (3) engagement sessions, a client is considered a fully enrolled PCM client.

Protocols for inactivating a client should at minimum include the steps outlined in the engagement and discharge planning sections of these standards.

Discharge Planning

STANDARD:

- ***A protocol for client discharge must be established.***
  - ***The protocol must include the following for all PCM clients:***
    - ***Assurances that clients are connected to and actively receiving needed resources and services at the time of discharge.***
    - ***Documentation in client record of discharge summary and disposition/termination of case management/client relationship.***
    - ***Determination and documentation of client discharge by supervisor.***
  - ***For clients who drop-out/withdraw from service:***

        - ***For those with more than three sessions, (3) three documented attempts to contact must be made before discharge, one of which must be an attempt to make a formal face-to-face contact.***

    For clients who move:

        - ***Case managers must make contact and transfer client care to another prevention case manager when possible.***
        - ***Clients must provide written consent to share records.***
        - ***All transfers must be followed-up.***
        - ***If case management services are not available, clients must be connected to needed resources and services, with active follow-up of referrals.***

- ***For clients who show a lack of involvement/progress:***
    - ***Client progress should be documented in the confidential client record.***
    - ***Clients must be informed of the short-term goals that need be achieved in order to remain in services.***
    - ***Clients must be offered referrals upon discharge as appropriate.***
    - ***Discharge must be determined by a supervisor.***
- ***For clients who successfully attain and maintain risk reduction goals:***
    - ***Clients who have successfully attained risk reduction goals will be included in the discharge planning process.***

Clients with lack of progress should be discussed with supervisor(s) and options and strategies to working with the client should be documented. This may include re-assessment, evaluation, and perhaps modification of client goals, if applicable. If strategies do not aid progress toward objectives, the PCM supervisor should meet with the client to discuss lack of progress and allow for additional input from client.

STANDARD:

- ***There must be a written protocol for client re-enrollment.***

Re-enrollment of clients that have been discharged through any of the above discharge methods, including clients who have achieved their risk reduction goals, but actively experience relapse or unsafe behaviors and/or barriers to risk-reduction, may be necessary.

OTHER PROGRAM CONSIDERATIONS

Staff Qualifications

STANDARDS:

- ***Staff qualifications must include:***
  - ***Knowledge of target population; cultural and linguistic competence; knowledge of HIV, AIDS, and other STDs; knowledge of available community services; knowledge of best-practices and evidenced based interventions for HIV/STD prevention; and effective communication skills.***
  - ***Documented work experience and training in case management and assessment techniques.***
- ***Prevention Case Managers must have the training and skills to perform the activities in their job descriptions and to deliver interventions.***

Staff Requirements

STANDARDS:

- ***All staff performing PCM must successfully complete all courses required in TDH program standards for PCPE and reflected in contract.***
- ***Staff must complete TDH approved PCM specific training.***
- ***All staff must be knowledgeable of confidentiality laws and agency confidentiality policies and procedures. Written documentation of this knowledge should be kept with employee file.***

Supervisor Qualifications

STANDARDS:

- ***Supervisors or lead staff should possess management skills and have experience and educational background in case management, nursing, counseling, psychology or social work.***

Supervisor Requirements

STANDARDS:

- ***PCM supervisors must be able to develop PCM program goals, objectives, protocols, and quality assurance and evaluation measures, as well as perform and assess interventions.***

Administrative Requirements

STANDARDS:

- ***PCM Staff must have written job descriptions and opportunities for regular feedback on their performance, training, and development.***
- ***Prevention Case Managers must have a written training and development plan related to the specific duties outlined in the job description.***
    - ***Staff must be provided with on going training and quality assurance to ensure effective identification of HIV risk behaviors and appropriate risk reduction strategies.***
- ***Agencies must maintain a system for recording all staff training. This must include employee name, date, type, source and duration of training. Copies of certificates should be kept in an employee file.***
- ***There must be a written organizational structure that shows the lines of accountability.***
- ***On site supervision must be available.***

Employee folders should include:

- Job description
- Performance guidelines
- Signed confidentiality statement
- Employee orientation form
- Staff development plan
- Records security procedures
- Emergency notification form
- Photo of employee
- Description of vehicle and license plate number

The PCM program staff should meet at a minimum monthly, to address core elements, program objectives, work plans, and progress reports. The meetings should be documented.

Quality Assurance and Program Evaluation

STANDARDS:

- ***Agencies must have formal written policies and procedures to ensure effective delivery of PCM services and adherence to standards of care.***
- ***These standards of care must include all standards included in this document as well as:***

Confidentiality: Refer to Health and Safety Code 81.103: http://www.capitol.state.tx.us/statutes/hs.toc.htm and chapter One, Prevention Counseling section 1.1.2 Confidentiality of the TDH Program Operating Procedures and Standards manual http://www.tdh.state.tx.us/hivstd/guidelines/pdf/PreventionCounselingStandards.pdf

Voluntary and Informed Consent: A client's participation must always be voluntary and with the client's informed consent. Documentation of voluntary, informed consent must be maintained in the client file. A client's informed consent is required before a prevention case manager may contact another provider serving that same client. Refer to Health and Safety Code 81.105 & 81.106: http://www.capitol.state.tx.us/statutes/hs.toc.htm

Cultural Competence: Organizations must make every effort to uphold a high standard for cultural competence. Programs and services must be provided in a style and format respectful of the cultural norms, values, and traditions that are endorsed by community leaders and accepted by the target population. Refer to the Office of Minority Health of the Department of Health and Human Services *National Standards for Culturally and Linguistically Appropriate Services in Health Care* as a guide for ensuring cultural competence in programs and services.
http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf

Professional Ethics*:* PCM must be governed by the same general professional ethics that govern most human service fields such as social work, counseling, nursing, and clinical psychology.

Duty to Warn: Organizations must be familiar with state and local procedures/requirements related to duty to warn other individuals at risk or in physical danger. Refer to TDH policy regarding How to Deal with Clients who Threaten to Harm Themselves or Others
http://www.tdh.state.tx.us/hivstd/policy/pdf/530003.pdf

STANDARDS:

- ***Quality assurance protocols must be developed and included in policy and procedure manual(s).***
- ***The evaluation plan must include written process and outcome monitoring objectives and evaluation methodology.***
- ***Quality assurance processes for client records/charts must at minimum assess for:***
  - ***Confidential storage of charts***
  - ***One record per client***
  - ***Client identification listed on all records***
  - ***HIV diagnosis***
  - ***A copy of the risk reduction plan with client signature***
  - ***Timely, legible progress notes including reason for visit, activities performed, milestones, referrals, follow-up plans, and PCM staff signature***
  - ***A client centered risk reduction plan signed by the client and periodically updated to reflect progress and set backs experienced***

- ***Meeting schedules***
- ***A copy of the voluntary informed consent, signed and dated***
- ***Logic model to guide risk reduction plan***
- ***Discharge plan and summary as appropriate, signed by supervisor***
- ***Client record retention and management must adhere to TDH Medical Record Retention Guidelines for Clinics and Doctors offices. The retention schedule can be accessed through the Bureau's webpage at:*** http://www.tdh.state.tx.us/hivstd/retention/default.htm
- ***Quality assurance of staff must be carried out according to TDH PCPE standards***

❖ ***Quality assurance plans must include a timeline for quality assurance, processes to assess client satisfaction including client feedback, staff reviews and an evaluation plan and timeline.***

Policy and procedure manuals should define the PCM intervention and how services will be provided.

There should be a designated staff member responsible for QA activities.

Also, refer to chapter 11, Minimum Standards for Client File Organization, Content, and Security of the TDH Program Operating Procedures and Standards manual. http://www.tdh.state.tx.us/hivstd/guidelines/pdf/ClientFileOrganizationStandards.pdf